CHAPTER 6

CENTER FOR MEDICARE AND MEDICAID SERVICES CONTRACT PROGRAM

Medicare Contracts

The Department of Health and Human Services (DHHS) has the overall responsibility for administration of the Medicare program, with the assistance of the Social Security Administration (SSA). The Centers for Medicare/Medicaid Services (formerly Health Care Financing Administration) is a component of DHHS. CMS has primary responsibility for Medicare, including: formulation of policy and guidelines; contract oversight and operation; maintenance and review of utilization records; and general financing of Medicare. SSA is responsible for the initial determination of an individual's Medicare entitlement, and has the overall responsibility for maintaining the Medicare master beneficiary record.

Title XVIII of the Social Security Act, entitled "Health Insurance for the Aged and Disabled," is commonly known as "Medicare". As part of the Social Security Amendments of 1965, the Medicare legislation established a health insurance program for aged persons to complement the retirement, survivors and disability insurance benefits under Title II of the Social Security Act.

When first implemented in 1966, Medicare covered most persons age 65 and over. Since then, legislation has added other groups: starting in 1972, persons who are entitled to Social Security or Railroad Retirement disability benefits for 24 months or more, and persons with end-stage renal disease (ESRD) requiring continuing dialysis or kidney transplant are entitled to Medicare benefits: and starting in 1973, certain otherwise non-covered aged persons who elect to buy into Medicare.

Medicare consists of two parts: hospital insurance (HI), also known as "Part A:" and supplementary medical insurance (SMI), also known as "Part B." When Medicare began on July 1, 1966, there were 19.1 million persons enrolled in the program. By the end of 1966, about 38 million persons were enrolled in one or both parts of the Medicare program.

The Board of Trustees, which is composed of two appointed members of the public and four ex-official members, holds the trust funds for both Part A and Part B. The Secretary of the Department of Treasury is the managing trustee. The Board of Trustees reports the status and operation of the Medicare trust funds to Congress on or about the first day of April each year

State agencies (usually State Health Departments under agreements with CMS) assist by helping DHHS to identify, survey, and inspect provider and supplier facilities or institutions wishing to participate in the Medicare program. In consultation with CMS, they then certify those that are qualified. The State agency also assists providers as a consultant, and coordinates the various State programs to assure effective and economical endeavors.

Medicare claims are processed by non-government organizations or agencies that contract to serve as the fiscal agent between providers and the Federal government to locally administer Medicare's Part A and Part B. These claims processors are know as "intermediaries" and "carriers."

Medicare "intermediaries" process HI claims for institutional services, including inpatient hospital claims, skilled nursing facilities, home health agencies, and hospice services. They also process outpatient claims for SMI. Examples of intermediaries are the Blue Cross and Blue Shield Association (which utilize their plans in various States), and the other commercial insurance companies. Intermediaries' responsibilities include: determining costs and reimbursement amounts; maintaining records; establishing controls; safeguarding against fraud and abuse or excess use; conducting reviews and audits; making the payments to providers for services; and assisting both providers and beneficiaries as needed.

Medicare "carriers" handle SMI claims for services by physicians and medical suppliers. Examples of carriers are the Blue Shield plans in a State and various commercial insurance companies. Carriers' responsibilities include: determining charges allowed by Medicare; maintaining quality of performance records; assisting in fraud and abuse investigations; assisting both suppliers and beneficiaries as needed; and making payments to physicians and suppliers for services which are covered under Part B.

Section 1816 of the Social Security Act provides the Secretary with authority to contract for Medicare fiscal intermediary functions. It also, allows institutional providers to "nominate" an appropriate entity to serve as their Medicare fiscal intermediary and, while the Secretary is not required to accept all provider nominations, the Secretary has no authority to contract for fiscal intermediary functions outside the nomination process. Section 1816 also permits such providers to request a change in their servicing intermediary in keeping with regulations established by the Secretary. Intermediaries are given an unusual right to terminate their contracts during a contract performance period, while the government must provide a public hearing to the intermediary in order to terminate a contract Other provisions allow for the automatic renewal of the contracts on an annual basis in keeping with CMS's appropriation cycle, and specify process parameters relating to the evaluation of these contractors. There provisions have been incorporated into agency regulations (at 42 CFR 421.100 and following).

Since the inception of Medicare, CMS has contracted out the performance of the Medicare program's front-line operational functions to a set of contractors known as the Medicare intermediaries and carriers. Medicare intermediaries handle claims for benefits submitted by institutional providers such as hospitals and skilled nursing facilities, and Medicare carriers process claims involving services furnished to beneficiaries by physicians and suppliers. In addition to making determinations on Medicare claims, the intermediaries and carriers perform a wide range of related benefit administration functions.

All current Medicare intermediaries have essentially held their contracts since the beginning of the program in 1965-6. At that time, the American Hospital Association and some other provider trade associations nominated the national Blue Cross Association (BCA) to serve as the Medicare intermediary to their membership. CMS and the BCA then entered into a "prime contract" which continues in force to this day through the annual automatic renewal process. In turn, the BCA subcontracted most operational FI functions to its member Plans (CMS is a joint signatory to these contracts.). Over time, many of the original Plans have either lost or ended their contracts, but the Medicare responsibilities of the outgoing Plan have always been transferred to another BCBS Plan already serving as a fiscal intermediary.

Quality Improvement Organizations (QIO's)

The Medicare QIO program was created as a result of Title XI of the Social Security Act, as amended by the Peer Review Improvement Act of 1982. The intent of the program is to:

- Improve the quality of care for beneficiaries by ensuring that beneficiary care meets professionally recognized standards of health care;

- Protect beneficiaries by addressing individual cases such as beneficiary complaints and provider issued notices of non-coverage; and,

- Protect the integrity of the Medicare Trust Fund by ensuring that Medicare pays only for services/items that are both reasonable and medically-necessary as well as provided in the appropriate setting.

The QIO contracts are legislatively mandated to be three years in length and are renewable under certain statutory conditions as defined in Title XI. There are currently 53 QIO contracts covering each State, the District of Columbia, Puerto Rico, Hawaii and the U.S. Virgin Islands. The program cost to the Government through these contracts is approximately $800 million.

Over the past several years, the program shifted in emphasis to community-based quality improvement and beneficiary education activities. The Quos work with the medical community to take the textbook medical findings and operationally them. During the current contract cycle, the QIO efforts are broken out in tasks as follows:

Task 1: Beneficiary Safety from a Clinical Perspective

The Quos are to ensure beneficiary safety in a multitude of settings such as nursing homes, home health agencies, hospitals, doctor's offices, rural settings and managed care settings.

Task 2: Beneficiary Safety from a Communication Perspective

The Quos are to promote the use of performance data – the measuring and disseminating of quality of care information on all providers as a part of the Medicare education program. Under the current contract, the Quos have been particularly focused on the Nursing Home Quality Initiative to implement an expanded and improved set of performance measures for nursing homes.

Task 3: Beneficiary Safety from a Protection Perspective

Within this task, the Quos concentrate on resolving beneficiary complaints as well as monitoring hospital work performed on Medicare beneficiaries.

End Stage Renal Disease Networks (ESRD Networks)

The Medicare ESRD program is the result of Section 1881 of the Social Security Act, as amended by the Omnibus Reconciliation Act of 1986. The intent of the program is to:

- Improve the quality of health care services and quality of life for ESRD beneficiaries;

- Improve data reliability, validity and reporting among ESRD providers/facilities, Networks and CMS;

- Establish and improve partnerships and cooperative activities between ESRDS, Quality Improvement Organizations, State Survey Agencies, ESRD providers/facilities, Medicare Choice (M+C) Organizations as well as other professional groups.

- Support the marketing, deployment and maintenance of CMS approved software known as the Consolidated Renal Operations in a Web-enabled Network (CROWN).

The ESRD Networks are designed to be three years in length and contain performance-based requirements as well as non-performance-based requirements. There are 18 Network contracts covering each State as well as Guam, Puerto Rico and the Virgin Islands. The approximate dollar value of the Network program is $50 million/three year cycle. A major emphasis under the current contract cycle revolves around health care quality improvement in the area of national vascular access improvement. In accomplishing this improvement, the Networks work with each other as well as other stakeholders such as providers/facilities, the National Kidney Foundation, etc. The ESRD Networks are also responsible for addressing local needs of facilities in their geographic area as well as beneficiary needs (such as complaint/grievance resolution.